



Experiences of person-centredness in pre--registration nurse education:The introduction of the Northern Ireland Bereavement Strategy (DHSSPS 2009) at Ulster University

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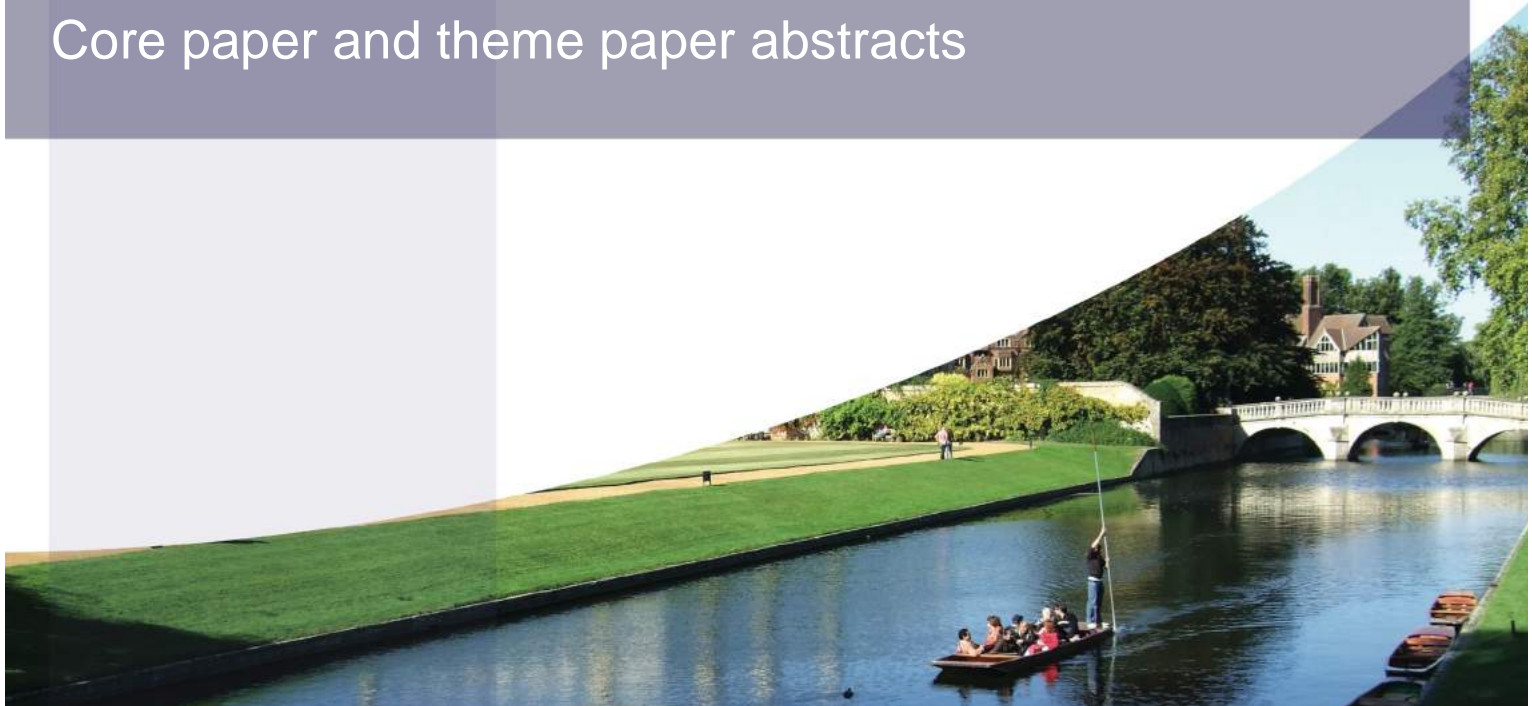
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Group 2 of theme sessions

Wednesday 9 September 2015

Humanising healthcare education

Core paper and theme paper abstracts



Group 2 of the theme sessions

Wednesday 9 September 2015

Humanising healthcare education (HHE)

Core paper and theme paper abstracts

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Core paper

Biographical details of core presenters

Linda Kenward, Principal Lecturer in Nursing and Midwifery, University of Cumbria, UK

Linda Kenward is currently Principal Lecturer at the University of Cumbria having previously worked for The Open University. Her academic experience includes working with NHS Education Scotland, as a consultant to the BBC and in a variety of academic and practice education posts in England. Linda is a Registered General Nurse as well as a Specialist Community Public Health Nurse (School Nursing), and has worked in supporting children and families in crisis.

Linda has a special interest and expertise in supporting traumatised patients and is an Integrative Counsellor registered with the British Association of Counselling and Psychotherapy, working with CRUSE Bereavement Care Scotland as well as having a small private caseload.

Traumatised patients: Helping nursing students acknowledge and understand the long-term effects of healthcare acquired trauma

Linda Kenward, Principal Lecturer in Nursing and Midwifery, University of Cumbria, UK

With a review of UK nurse education expected following the *Shape of Caring Review* (2015), this paper will contribute to the debate around the need for adult nurses to be able to respond to a broad array of presenting issues in their patients, specifically awareness of mental health issues. The focus will be on trauma experienced as a result of interaction with the healthcare system in the form of unintentional neglect, misdiagnoses, surgical errors and mismanagement of care. For the purposes of this paper trauma can be defined as any severe and debilitating psychological distress that occurs as a result of incidents in a healthcare setting. This could include trauma symptoms of post-traumatic stress disorder (PTSD) as defined by the Diagnostic and Statistical Manual of Mental Disorder (DSM 5) (American Psychiatric Association, 2013), but might include undiagnosed distress presenting as symptoms of anxiety or depression.

Harm happens in healthcare systems. The World Health Organisation (WHO, 2015) estimates that complications after surgery occur in up to 25% of patients and that in industrialised countries, nearly half of all in-patient adverse events are related to surgical care with at least half of cases leading to harm being preventable. Even in the most carefully managed environment mistakes are made. In the UK, the rhetoric around cultures of care and patient safety changed with the realisation that abuse, negligence and errors happen more regularly than is desirable and a greater emphasis on compassion and patient safety has come from both a recognition of past mistakes and the increasing fear of litigation (Illingworth, 2014). With the duty of candour, there is an increased awareness of the role of honesty in the relationship between patients and clinicians (Care Quality Commission, 2014). The fact that avoidable deaths occur as a result of the poor quality of care has been a recent feature of investigative reports such as the recent Kirkup Report (2015). However, the recognition that non-fatal incidents might lead to significant trauma is hardly every acknowledged, other than in specific settings or situations.

In nursing setting the recognition of the impact of traumatic births is well researched as is the psychological impact of treatment in intensive therapy unit (ITU) resulting in PTSD or serious psychological long term implications (Oldea *et al.*, 2006; Ratzer *et al.*, 2014). Patients who experience other types of what might be termed healthcare acquired trauma (HAT) rarely have their trauma acknowledged or the long term consequences recognised. Traumatic hospital experiences may not result in a formal diagnosis of PTSD or trauma symptoms, but for those who develop serious symptoms of distress it is an experience that changes and shapes the way in which an individual views themselves, their future or the world resulting in long term psychological distress, an inability to manage daily life and a fear of the future, especially the possibility of further interaction with the healthcare system (Beck, 1979).

Levenson (2007) acknowledged that a traumatic hospital experience could precipitate incidences of PTSD or psychological distress but healthcare acquired trauma can often go unacknowledged or be minimised by clinicians following formal apologies or compensation offers giving the perception that the matter has been addressed. Indeed, some patients may be required to sign a non-disclosure order that does not enable them to talk freely about their experience, share the distress that occurred to enable them to progress towards recovery or to share learning from that experience with the wider healthcare community. Patients frequently hear that 'lessons have been learnt' following serious incidents but rarely see the long-term benefits of those lessons in the reshaping of services to allow acknowledgement of that trauma. The idea that patients are traumatised, not only by illness but by the manner that care is delivered or managed is an uncomfortable one, not only for patients themselves, but also for clinicians whose focus it is to care and minimise harm. Alongside a lack of recognition that the healthcare system can itself harm and cause trauma goes an understandable reluctance to talk about this. The literature around healthcare acquired trauma that does not include ITU or traumatic birth episodes is therefore sparse in the UK and Europe, but mental health settings in the USA and Australia have made significant strides in recognising that harm that can be caused purely by interaction with the system and are currently moving toward trauma informed care (Bremness and Polzin, 2014; Watson *et al.*, 2014). Randall and Haskell (2013) define becoming trauma informed as:

'...becoming more astutely aware of the ways in which people who are traumatized have their life trajectories shaped by the experience and its effects, and developing policies and practices which reflect this understanding' (pp. 501)

This has yet to happen within general healthcare in the UK and Europe, but it seems as though this might be a timely and appropriate discussion.

In order to change what happens when people experience trauma in a healthcare setting there needs to be a greater understanding and acknowledgement by clinicians of the contributing factors to the experience. Nurse educators can help develop and share this understanding with their students. However, no major study has as yet researched the long-term impact of healthcare acquired trauma. Research on PTSD by Elhers and Clark (2000) informed a psychosocial model of trauma that has been important in moving forward treatments for those experiencing trauma generally. Studies of those with PTSD show that trauma caused by the actions or omissions of people rather than, for example natural disasters, has the

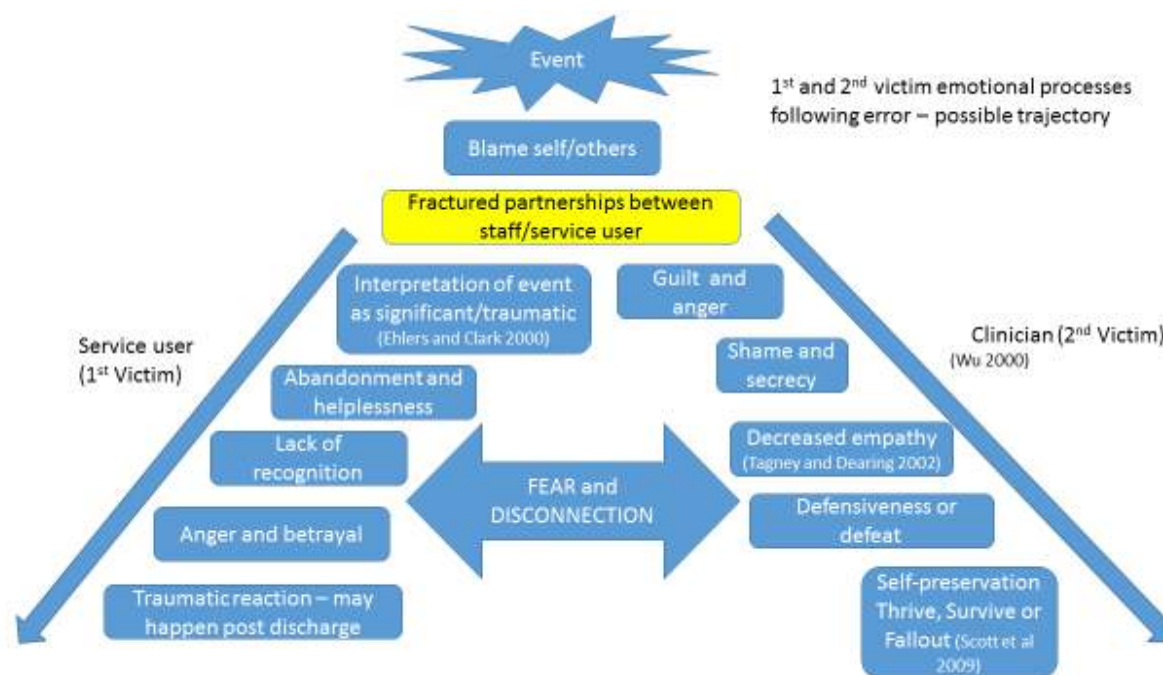
potential to cause significantly greater harm psychologically. Interpersonal factors seems to compound the trauma (Brewin, 2003). This is particularly significant in trauma that is experienced in the healthcare setting, as patients generally enter the system with an expectation of care, even if the system is acknowledged as not being perfect. Brewin's work considers the fact that not all those who experience a trauma go on to develop a traumatic reaction but that a range of factors including previous life experience, attachment style, personal beliefs about oneself and others, all impact on whether a long-term traumatic stress reaction occurs (Brewin, 2009).

The work of Vincent on patient safety emphasises that 'unsafe acts' happen all the time but that many are picked up sufficiently early to allow outcomes to not be damaging (Vincent, 2010).

It seems then that a 'perfect storm' of a vulnerable individual, in terms of the factors mentioned by Brewin, and an adverse event connect to make a specific set of circumstances that may bring about a traumatic reaction. The work of Wu (2000) and Scott *et al.* (2009) on the 'second victims' of errors in healthcare considers the healthcare practitioner. Wu and Scott's work, and that of others in their field examines the emotional reaction of the practitioner to making errors in practice. It is acknowledged that healthcare workers can also develop a traumatic reaction similar to that of the patient. This recognition in the USA has brought about advanced second victim programs for clinicians alongside trauma informed care programmes for patients (Krzan *et al.*, 2015).

It is significant to note two things in the body of research work already undertaken. First, it is noticeable that in reports of the management or aftermath of errors it is the description of what occurred in factual terms that is the focus of the research work. Human emotion and feelings are rarely seen as significant when the primary focus is in finding ways of managing harm. Secondly, there is no recognition of what helps the situation for patients and therefore what might protect them from developing a traumatic reaction in the future. The work of Vincent (2010) acknowledges the need for candour, that since 2014, is now firmly in place following the Mid Staffordshire Review (2013). While simply being honest, open and transparent with patients and with staff is a major step forward, an acknowledgement of the barriers that make this difficult when experiencing an traumatic patient event is also a key aspect of the patient clinician relationship. One of the significant factors in enabling those who have experienced trauma is access to initial and post trauma support (Andrews *et al.*, 2003). However, Robinaugh *et al.* (2011) established through their work that the support would need to be positive in relation to allowing the victim to reframe and to reappraise the trauma rather than just a traditional debriefing. This fits well with the current cognitive behavioural therapy (CBT) practice in terms of cognitive restructuring, exposure therapy and eye movement desensitisation and reprocessing as recommended by National Institute for Health and Care Excellence.

What then can a nurse do in relation to supporting and potentially preventing a traumatic reaction to a significant event? A possible trajectory of emotions for both first and second victims is offered for discussion and has been developed through informal work with patients and an appraisal of the relevant literature on second victims.



This trajectory requires further work including a pilot project to ensure a robust evaluation and reworking but a key feature in patient reports is the fracturing of the patient/clinician relationships at an early stage following the incident. This feature has also been identified by Vincent (2001) as being a 'second trauma' to those involved and cuts across the need for support

that traumatised patients' need to aid recovery. Systems and processes are set up to avoid errors and ensure that they are anomalies or 'never events', yet they still happen (Jones *et al.*, 2012). Expectations are shattered and the patient – clinician relationship breaks down. This can be compounded by a lack of honesty and an unwillingness to admit mistakes which may lead to avoiding engagement with the patient. At that point the mutual respect and support that each has for the other may be replaced for the patient by a reappraisal of what has occurred as being harmful and threatening. The clinical setting feels like a dangerous place. The trajectory of emotions felt by clinicians has been researched by Wu (2000), Scott *et al.* (2009) and Jones *et al.* (2012) with the acknowledged impact of these emotions upon the clinician being considerable. Disappointment in performance, shame, guilt and fear are key emotions for clinical staff following a difficult patient event. Shame researchers Tagney and Dearing (2002) found a clear link between the emotions of guilt, shame, and anger with a decrease in the ability to be empathic which clearly has implications for the continued care of traumatised patients. Davidoff (2012) in his discussion of the relationship between shame and perfectionism notes that healthcare professionals are self-selected for perfectionism when entering the profession – they want to be good at what they do. What matters then, is the response in the clinician to these feelings that ensures that difficult feelings do not distance them from the patient at a time when the relationship is crucial. Maintaining the relationship gives the clinician a significant opportunity to allow for further planning, support and care that may help to minimise, validate and acknowledge the trauma felt by the patient. Repairing of the relationship can only take place whilst dialogue continues and this requires clinicians who are aware of their emotions, who understands the trajectory of emotions when things go wrong and are astute enough to be able to respond to the emotional distress of their patients appropriately.

Educators are charged with developing highly competent and confident students, a responsibility which they rightly take extremely seriously. Given the challenging nature of practice settings nurse education must include helping students to understand the nature of trauma, trauma responses and recognition as well as the ability to respond appropriately to the difficult circumstances and feelings around a significant event (as defined by the patient). Students require a greater awareness of their own difficult feelings, including feelings of inadequacy, failure and shame in a profession that fears vulnerability and inadequacy and sometimes maintains 'professionalism' as a barrier. Educators are well placed to make explicit the importance of maintaining a strong therapeutic relationship after significant events even when feelings of vulnerability, shame and distress run counter intuitively in the clinician. Ensuring clinicians are aware of their own usual cognitive processes, systems of support, strengths and weaknesses as well as their professional responsibilities is an initial step forward in providing trauma informed nurses that can support patients should adverse events occur.

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Theme papers

Nursing spiritually: What do we know? How do we know?

Ruth Brown, Senior Lecturer, University of Huddersfield, UK

The Office of National Statistics (2011), produced figures from the census and shows that here in the UK we have a more diverse community than any other country in Europe, contributing to the richness of spiritual understanding. However, this diverseness also creates differences of understanding. The last three decades have shown a significant increase in recognising the importance of spirituality and how caring for a person's spiritual needs can have a positive impact on their mental well-being (Narayasamy, 1999; Pesut *et al.*, 2007). The Chief Nursing Officers Review (2006) recommended mental health nurses act in response to identified spiritual or religious needs of the individual. However, this is still approached with uncertainty by some nurses who are reluctant to engage with it despite professional requirements to address this aspect of care (McSherry, 2011). Swinton (2006) suggests this reluctance is a fear of imposing their views on a person who is already vulnerable. This may be exacerbated because nurses are often unaware of what constitutes spiritual need and are unprepared to recognise it in others (Castledine, 2005; McSherry, 2011).

Religion and spiritual beliefs particularly in these sensitive times are often difficult topics and coupled with mental health needs may even make it an almost taboo area to address. Serious mental illness often runs hand in hand with diminished capacity, mental health act applications, possessiveness and fixed beliefs which has the propensity of distorting what could actually be an expression of spiritual need (Barker, 2004). A mental health nurse may fear misinterpreting the spiritual needs of the service user with symptoms of mental illness which may cause a reluctance to provide spiritual care (Barker, 2004; McBrien, 2006). Cohen *et al.*, (2000) states with the absence of a single scientific definition of spirituality, boundaries of providing spiritual and religious care have been blurred. Swinton (2001) suggests this dichotomy has not helped in terms of how a mental health nurse can provide spiritual care for service users without fear of imposing personal beliefs on them.

The Royal College of Nursing (2010) commissioned an online survey to try and establish the understanding and attitudes of nurses towards spirituality as a concept and the provision of spiritual care. The findings of the mixed method analysis revealed that despite nurses recognising spirituality as a fundamental aspect of nursing care, many of the respondents felt that they in turn needed support and education to enable them to feel confident in providing it. However, the study did not differentiate the responses in relation to the fields of nursing.

This presentation will highlight the progress so far on the research I am currently facilitating as part of a Professional Doctorate, which is: an exploration of mental health nurses' understanding of spiritual needs of service users. One of the outcomes of the research is to consider how mental health nurses may be educated and supported to identify and address spiritual needs and improve the service user experience.

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Key words:

- Spirituality
- mental health nursing
- education
- research.

How this contributes to knowledge development within this theme:

- to evaluate how providing spiritual care is currently facilitated in nurse education
- to discuss how different this is in terms of mental health nurse education
- to consider how pre and post-registration mental health nurses may be educated in supporting spiritual needs of service users whilst practicing the principles of the '6 Cs'.

G2HHE-T2**Abandoning a failed paradigm: From diagnostic to narrative understandings of human misery**

Alec Grant, Reader in Narrative Mental Health, University of Brighton, UK

A consensus standpoint within contemporary critical psychology and psychiatry is that the medicalization of human misery, represented by psychiatric diagnoses, thrives because of its connections to other structures of power (Bentall, 2009; Rapley *et al.*, 2011; Johnstone, 2014). These include the global pharmaceutical industry, socio-political, criminal justice, popular cultural and economic interests, and mental health professional, policy and research discourses. Although subject to robust critique for lacking scientific credibility (Bentall, 2009; Cromby *et al.*, 2013; Johnstone, 2014), diagnostic portrayals of human distress maintain a high level of international cultural hegemony. Reified in contemporary global media, celebrity culture and UK manifesto party politics, they constitute the lingua franca connecting public with mental health professional, research and policy discourses. Hornstein (2013) conveys the strength of such hegemonic acceptance in her assertion that diagnostic understandings of human misery are sedimented in public and professional consciousness to the extent that, collectively, they constitute an authoritative meta-narrative to guide human life and experience.

However, a paradigm shift is underway, described and discussed in the above contemporary de-medicalization literature, from diagnostic to narrative-based understandings of human distress (Hornstein, 2013; Thomas and Longden, 2013; Johnstone, 2014). As a stakeholder in this shift from a number of interrelated identity positions, my subjectivity is unashamedly valued and inscribed within it (Grant *et al.*, 2013). With colleagues, I have for several years written critically about our involvement with mental health services and the relationship of this to healthcare education, in relational autoethnographic work. We have done so in increasingly existential rather than psychiatrised ways, on the basis of our hybrid identity positions, as mental health academic-professionals-survivors (Short *et al.*, 2007; Grant, 2013; Grant and Leigh-Phippard, 2014; Grant *et al.*, in press). Such re-storying of our life narratives has enabled us to construct and develop viable identities, relatively independent of the institutional mental health system, and free from the pejorative labels that were once imposed on us by this system.

Through engaging in this emancipatory writing, I have become increasingly interested in its connection with the de-medicalization literature. After describing the rationale for the paradigm shift, its contextual bases, main features and constraining and enabling factors, my paper will situate the significance of our narrative work in relation to this literature. This will pave the way for a discussion of some general and specific emerging implications for necessary changes to healthcare education, aimed at changing workplace practice and ways of talking and writing about human distress, and influencing new research directions.

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Key words:

- de-medicalizing misery
- paradigm shift
- narrative approaches
- representational practices
- critical mental health.

How this contributes to knowledge development within this theme:

- increased reflexive awareness of the structures of power that give rise to diagnostic representations of human misery
- educational practices in healthcare that embrace non-diagnostic, non-medicalized forms of representational practices as an emerging alternative to diagnostic forms
- increased understandings of contemporary narrative-based approaches to understanding and responding to human distress.

G2HHE-T3

Experiences of person-centredness in pre-registration nurse education: The introduction of the Northern Ireland Bereavement Strategy (DHSSPS 2009) at Ulster University

Debbie Goode, Lecturer in Nursing; Jacinta Lynch, Lecturer in Nursing, Ulster University; Carole Mckeeman, Bereavement Co-ordinator; Emma King, Macmillan Palliative Care Facilitator for Western Health and Social Care Trust, Londonderry, UK

Aim

To share our strategies and experiences of the impact of providing person-centred end-of-life care for the person and the family within a pre-registration curriculum.

In common with all tertiary education institutions, Ulster University is tasked and committed to ensuring that nursing students graduate with the capabilities to deliver appropriate care to people requiring end-of-life care (Nursing Midwifery Council, 2010). The curriculum was developed with the theoretical perspective of person-centredness based on the Person-Centred Practice Framework (McCormack and McCance, 2010).

The vision for person-centred care was to develop a three year plan with student learning outcomes and competencies mapped as a thread throughout the course. In partnership with the Western Health Social Care Trust bereavement coordinator and the Macmillan palliative care facilitator, an end-of-life care teaching plan was developed and delivered throughout the three year programme. The aim is to ensure that nursing graduates are personally equipped with the tools to deliver care at end-of-life in a compassionate, sensitive manner embracing the personal beliefs, cultures, and practices of individuals and their families and carers. In essence this initiative has allowed us to embrace the Northern Ireland Bereavement Care Strategy (2009) and the Final Journeys (Irish Hospice) training within the undergraduate nursing programme.

The literature repeatedly suggests that nursing students are not adequately prepared for end-of-life care, often requiring more education on the theory and practice of end-of-life care (De Souza and Pettifer, 2013; Reading and Webster, 2013; Adesina *et al.*, 2014). Nursing students require continuous support and development of their own personal coping strategies (Ek *et al.*, 2014). It is vital that the interdisciplinary team members who have the most contact with the patient and their family are trained and equipped to provide the most appropriate, evidence informed, person-centred end-of-life care

(Adesina *et al.*, 2014). Many educational methods have been suggested in the literature to address these deficits. The use of simulation has been explored by several authors and found to be beneficial to the student as it allows the exploration of ethical dilemmas in a safe environment (Moreland *et al.*, 2012; Fabro *et al.*, 2014; Gillian *et al.*, 2014). Other pedagogical approaches that also improve knowledge and confidence include online courses (Conner *et al.*, 2014), 'high fidelity and gaming' approach (Kopp and Hanson, 2012) and real life case studies (Bailey and Hewison, 2014).

Since 2011, the current programme at Ulster has strived to enhance the knowledge and skills of the student nurse in relation to end-of-life care, using a combination of pedagogies. Person-centred care has been developed through the awareness of self and critical thinking, clarity of beliefs and values, and the importance of professionalism and personhood (McCormack and McCance, 2010). Student feedback would suggest that their learning on this topic has been beneficial in preparation for end-of-life care, both in personal and professional terms (Dickson *et al.*, 2008).

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Key words:

- person-centred
- end-of-life
- compassion
- nurse education.

How this contributes to knowledge development within this theme:

- students should develop the necessary skills to critically reflect and care for 'self' during end-of-life care in professional and personal context
- preparation of nursing students toward a greater awareness of end-of-life care strategies prior to and during their practice learning experiences
- students should be equipped with the necessary knowledge and skill set to engage in the provision of person-centred end-of-life care in a changing health care environment.

Service users contribute their lived experiences to child branch nursing students

Carol Blackmore, Senior Lecturer, University of Central Lancashire, UK

Aim

To demonstrate how the contribution of service users can enhance empathy and understanding within the child branch nursing students.

Introduction

The importance of service users in healthcare education has been recognised as a requirement as cited in the Nursing and Midwifery Council's Standards for Pre-registration Nursing Education (NMC, 2010) along with recommendations of increased service user involvement in all aspects of healthcare education (QAA, 2005).

Children's nursing is strongly focused on the child within the family unit so it is important for student nurses to understand the healthcare experiences of both the child and the family. Parents' views can be helpful in gaining useful insights into some of the difficulties they face caring for a sick child. This can help to develop students' empathy and understanding towards the parents/carers in relation to their lived experience of having a child with a chronic illness. A variety of perspective can be obtained using a wide range of sources from service users in the classroom, to research studies of parent/child experiences, case studies and the use of video clips.

At UCLAN we have been using service users within the children's nursing curriculum for over 10 years. Parents with experience of caring for sick children contribute to the learning experience of our students in several ways. Parents are involved with the students OSCE assessments while the student nurses are carrying out a variety of skills on the child manikins they also have to communicate appropriately their actions whilst reassuring and answering questions to the 'parent/carer'. The service users at the end of the examination are involved in the written feedback given to the student, regarding the students' communication skills, considering key components of nursing such as the demonstration of caring and compassion.

In the classroom the child and families' experiences are considered in relation to the subject being presented, for example, caring for children with genetic disorder, video clips are available in the NHS website www.geneticseducation.nhs.uk showing a child and mother's perspective of living with the condition of Down's syndrome is just one example.

Service users also are willing to come into class to speak to student nurses on their experiences of caring for children with learning disabilities both in hospital and at home. This provides students with useful insights into their needs and their views on what they have found to be most helpful in meeting these needs within the services available. This is also reflected in health and social care policy (DH, 2010).

Students' evaluations of service user input is very positive including comments such as: 'I enjoyed the parent coming into talk . . . a lot of the stories are very moving.'; 'Nice to hear from a parent's point of view.'; 'Felt it made us understand more on the other side and what they felt and what they were going through.'; 'Enjoyed the guest speakers who came in and gave their view on how life is living with a child with learning disabilities.'

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Learning outcomes

1. Recognise the benefits of service users in the classroom to give student nurses a lived experience of the challenges they face caring for a child with learning disabilities.
2. To demonstrate a variety of ways that care and compassion can be included within teaching sessions in the classroom environment.

Using standardised patients for advanced psychiatric nursing assessment

Gayle Langley, Senior Lecturer; Hilary Thurling, Lecturer, University of Witwatersrand, South Africa

In psychiatric practice, the health practitioner and patient relationship is the cornerstone of effective caring and one of the most important factors predicated the success of the therapeutic alliance (Hojat, 2007). It is a complex, multidimensional concept which has affective and cognitive elements and requires the ability to identify with the person, communicate understanding, inspire trust and enable the mutual identification of goals, plans to achieve them and then assist the person to work toward these goals. Empathy is an essential part of this therapeutic relationship (Mercer and Reynolds, 2002) and the development of empathy amongst nurses can often be difficult (Chaffin and Adams, 2010).

Relational skills must be fostered and practised by candidates reading for an advanced qualification leading to registration as specialist practitioners (Advanced Psychiatric Nurse).

Educators need to assist the aspirant specialist practitioners to acquire the theoretical knowledge, technical skills and confidence to ensure that their practice is proficient, competent and safe. Students reading for an MSc or Advanced Diploma in Psychiatric Nursing are experienced, registered psychiatric nurses. Many have practised for years in psychiatric settings. Their role is mandated by the professional scope of practice prescribed by their registering authority (in this case, the South African Nursing Council). Although trained in individual counselling and group work, they frequently opt to assume a supportive stance in relation to other members of the multi-disciplinary team.

In order to encourage students to engage with issues related to the therapeutic relationship and to enhance their communication skills with patients that might be experiencing emotional distress, standardised patients were introduced to augment the experiential component of the course.

Following a two day workshop on 'narrative therapy' theory and methods with a wide variety of psychiatric and counselling practitioners (professional and lay), the students practised the application of the principles, attitudes and skills learned with their lecturers. Empathy was a core component of the course.

As the students are employed at different mental health institutions and attend lectures and seminars on a day release programme, some travelling several hundred kilometres to do so, it was decided that the clinical examination (a course requirement) would be held at the university using standardised patients to assess their interviewing and therapy skills. Empathy levels were measured using the medical student version of the Jefferson Scale of Physician Empathy (JSPE) (Hojat *et al.*, 2001).

A degree of expertise was required of the standardised patients to be able to simulate patient problems, attitudes and symptoms. A script was developed and the standardised patients were carefully prepared and practised the interaction under the tutelage of the lecturers. They each portrayed a client for an hour for four students (twelve in total) and then gave feedback to the student and the presiding examiners, of the therapeutic interaction, and the degree of empathy that they experienced in the interview.

This qualitative study reports on the experiences of the lecturers, and the students, and the standardised patients. Students indicated that they found the format and the experience engaging and rewarding and that they felt both empowered and valued. Verbatim excerpts from the students' written reviews of the process and records of the standardised patients are provided to illustrate the descriptions and the recommendations posited. The lecturers realised the possibilities of using standardised patients to illustrate the difficult emotive aspects in psychiatric nursing that often can only be taught with patient interaction. The standardised patients gave extremely important feedback to the students and we believe will be instrumental in developing the student's confidence in their own ability which will result in improved patient care and an increased involvement by the psychiatric student nurses in patient care.

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Key words:

- standardised patients
- Advanced Practice Nursing Education
- assessment methods.

How this contributes to knowledge development within this theme:

- experiences of lecturers, students and standardised patients in presenting and participating in a complex scenario for assessment
- preparation of standardised patients for a complex role, eliciting nurse empathy
- the value of 'patient' feedback as experienced by students after assessment.

G2HHE-T6**The mediating role of personality in relation to breach and violation of the psychological contract and its moderating impact on coping in a health setting**

Patricia Hornby Atkinson, Senior Lecturer; Helen Wall, Lecturer; Demetria Darbyshire, Research Assistant, Edge Hill University, UK

The psychological contract is described as a person's perception and expectation about the mutual responsibilities in an employment exchange relationship, and is characterised as being either transactional or relational (Rousseau, 1989). A transactional contract focuses on instrumental inducements such as competitive pay, whereas a relational contract focuses more on the social and emotional relations between both parties that allow for more relational inducements, such as opportunities for skill development (Montes and Irving, 2008). Perceived violation refers to emotional distress, feelings of betrayal, anger and wrongful harm arising from the awareness that your organisation has not fulfilled a highly salient promise (Morrison and Robinson, 1997; Rousseau, 1989).

Breach and violation of the psychological contract have been associated with various individual and organisational outcomes such as: a decrease in employee job satisfaction (Zhao *et al.*, 2007), low organisational commitment (Suazo *et al.*, 2005), absenteeism (Deery *et al.*, 2006), and higher staff turnover (Dulac *et al.*, 2008). However, if inequity is perceived to be apparent for a healthcare professional, in this case a nurse, it can lead to more dangerous consequences such as: emotional exhaustion, de-personalisation and reduced sense of professional accomplishment, all of which may have detrimental effects on a patient's care, for example patients apparently being treated in a less than caring manner (Schaufeli and Greenglass, 2001) or even neglect (Raja *et al.*, 2004).

Responses to a broken contract have been shown to lead to a variety of individual responses such as: 'exit', characterised by expressed intentions to leave or 'neglect', characterised by disengagement from work and caring; 'voice', characterised by expressing concern and even dissent in an attempt to bring about positive change; 'loyalty', characterised by avoidance of conflict and a belief that 'all will be well'; and 'sabotage' or 'destructive intent', characterised by actions meant to cause disruption and discontent (Cassar *et al.*, 2013).

The current study aims to develop and extend research into the Big-5 (Costa and McCrae, 1987) and assess how the construct of honesty-humility, as measured using the HEXACO (6 Factor) measure of personality (Ashton and Lee, 2009) might identify the specific personality factors associated with how nurses perceive violations in the psychological contract, which they consider themselves to be engaged in. For example, Jafri (2014) suggests individuals high on extraversion are more likely to perceive a breach as they actively seek out information due to their proactive nature, and consequently will evaluate how their organisation is treating their employees. Similarly, individuals who are highly neurotic are more likely to perceive a breach due to their tendency to think negatively of themselves and others, and thus naturally be more suspicious of those around them. Furthermore, a second aim of the study is to explore how personality differences mediate coping strategies employees choose to engage in after a breach or violation is perceived, and how successful are these coping strategies, for example, do extroverts tend to approach others and talk through their issues? If so, does this 'social approach' lead to effective outcomes in terms of their individual coping strategies or is it counterproductive? Here we present empirical evidence of these relationships based on a study conducted with nurse students of a North West HE institution.

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Key words:

- psychological contract
- healthcare
- violations
- personality
- coping strategies
- implications.

How this contributes to knowledge development within this theme:

- exploring how a Hexaco (6 Factor model of Personality) of healthcare professionals influence perceptions of a breach and/or violation in the psychological contract
- investigating how the 6 factors of personality are related to nurses coping styles and behaviours, upon perceiving a breach or violation in the psychological contract
- discussing practical implications that if implemented by healthcare organisations may help to prevent factors such as emotional exhaustion in nurses, and neglect in health care settings.

G2HHE-T7

Humanising healthcare education with narratives of care and compassion

Roger Newham, Senior Lecturer, Buckinghamshire New University; Louise Terry, Reader in Law and Ethics, London South Bank University; Sinead Hahessy, Lecturer, National University of Ireland, Galway, Ireland; Siobhan Atherley, Senior Lecturer, Canterbury Christ Church University; Yolanda Babenko-Mould, Assistant Professor; Marilyn Evans, Associate Professor; Karen Ferguson, Lecturer, University of Western Ontario, London, Canada; Graham Carr, Senior Lecturer, London South Bank University, London, UK

Recent reports (including the Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2013 and Aras Attracta Scandal, Ireland 2014) have highlighted the seemingly wholesale demise of care and compassion amongst healthcare workers in contemporary healthcare environments. Provocatively, some theorists have questioned healthcare educator's role and responsibility in devaluing the fundamental aspects of care and compassion as central tenets of healthcare education (Darbyshire and McKenna, 2013). This may be in part related to what Lynch (2010) terms the 'hidden doxa of carelessness' that has pervaded the wider culture of higher education at large and is predicated as she argues 'on a Cartesian view of

education, namely that scholarly work is separate from emotional thought and feeling'. Care and compassion are contradictory to the cultural values of the modern university which is increasingly commodified and this has implications for pedagogy (Winter and O'Donohue, 2012).

In a response to these challenges, this paper will report the results of an international interdisciplinary research project that aims to develop a narrative of caring and compassion by identifying and analysing a repository of key books, articles, poems, plays and films that have been most influential on our understanding of the importance of care and compassion. A research team of nine healthcare professionals involved in healthcare education from five universities, three in England, one in Ireland, and one in Canada, was formed. Ethical approval was granted from each university. For the pilot stage, each member of the research team was invited to nominate the most influential artefact that most conveyed caring and compassion to them, explain the underpinning rationale for their choice and how they used this item in educating health and social care students. This allowed for testing and refinement of the questionnaire and the analytical approach that was developed. Subsequently, fellow educators within the five universities were invited to participate by completing the questionnaire and nomination form.

The methodology, discourse analysis was chosen as it aims to make explicit what is implicit as taken for granted, and the effect upon individuals' lives as part of society (Cameron, 2001). It was important to see 'how language is used to 'construct' the ideas...' look for the 'inconsistencies of meaning in the constructions and the assumptions they reveal' and finally consider 'the implications of a particular account, to examine what the discourse achieves' (Burck, 2005). We developed a template drawing in part on Gee's (2011) toolkit for discourse analysis, developing additional questions and aiming to address the weaknesses that often occur in discourse analysis methods according to Stevenson (2004). To avoid under-analysis we delved beyond the quotations or words, by having more than one person analyse each nominated narrative, seeking negative or contradictory examples then having the whole research team analyse the analyses using thematic analysis.

The analyses of n = 38 questionnaires and the nominated items is nearing completion. The final abduction stage of analysis (anticipated to be completed by March 2015) involves analysing the whole data set using discourse analysis once again with the project leads synthesising the whole and obtaining agreement regarding the meaning of 'caring' and 'compassion' as revealed through this project. The results of this study will be presented at the conference, including the list of nominated books, articles, plays, poems and films in order to show how narratives of care and compassion can be used to humanise healthcare education and develop these important qualities in the next generation of health and social care educators.

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Key words:

- care
- compassion
- narratives
- discourse analysis
- healthcare education.

How this contributes to knowledge development within this theme:

- this research study offers a list of books, articles, plays, poems, and films that can be used by healthcare educators to humanise healthcare education by conveying caring and compassion or invoking these feelings through narratives of absence
- the researchers will reveal how experienced health and social care professionals engaged in the education of the next generation of practitioners understand 'care' and 'compassion'
- the discourse analysis method that was designed for this study will be shared in fuller detail to help other researchers interested in care and compassion or who may be considering discourse analysis for their own projects.



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Dr Kay Currie, Glasgow Caledonian University, UK
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Cambridge CB24 8RE
United Kingdom

Tel: + 44 (0)1954 252020
Fax: + 44 (0)1954 252027

jra@jillrogersassociates.co.uk

www.jillrogersassociates.co.uk

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